114.3 CMR 4.00: RATES FOR COMMUNITY HEALTH CENTERS

Adopted 12/21/04

Section

4.01: General Provisions

(1) Scope, Purpose and Effective Date. 114.3 CMR 4.00 governs the rates of payment to be used by all governmental units in making payment to providers of Community Health Center services to publicly-aided individuals on or after November 1, 2004. The rates set forth in 114.3 CMR 4.00 also apply to individuals covered by M.G.L. c. 152 (the Worker's Compensation Act).

(2) Authority. 114.3 CMR 4.00 is adopted pursuant to M.G.L. c. 118G.

(3) Disclaimer of Authorization of Services. 114.3 CMR 4.00 is not authorization for or approval of the substantive services for which rates are determined pursuant to 114.3 CMR 4.00. The purchasing governmental agency, is responsible for the definition, authorization, and approval of services extended to publicly-assisted clients by Providers.

4.02: Definitions

Meaning of Terms. As used in 114.3 CMR 4.00, unless the context requires otherwise, terms shall have the meanings ascribed in 114.3 CMR 4.02.

Certification. Determination by the Division of Medical Assistance pursuant to 130 CMR 405.000

Community Health Center(CHC). A clinic which provides comprehensive ambulatory services and which is not financially or physically an integral part of a hospital.

Cost Report. The document used to report cost and other financial and statistical data in a format requested by and approved by the Division.

Division. The Division of Health Care Finance and Policy (DHCFP), established under M.G.L. c. 118G.

Early and Periodic Screening, Diagnosis and Treatment Services. A face-to-face meeting between an Early and Periodic Screening, Diagnosis and Treatment Services recipient and a physician, physician assistant, nurse practitioner, or registered nurse for the purposes of performing a comprehensive health assessment in accordance with the Division of Medical Assistance's Early and Periodic Screening, Diagnosis and Treatment Services regulations.

Eligible Provider. A community health center which meets the conditions of participation that have been or may be adopted by a governmental unit purchasing community health center services. Minimally, a community health center must meet the following criteria:

(a) In State: (i) Be licensed as a freestanding clinic by the Massachusetts Department of Public Health pursuant to M.G.L. c. 111, s.51, and (ii) meet the qualifications for certification (or provisional certification) by and enter into a provider agreement with the Division of Medical Assistance pursuant to 130 CMR 405.000
(b) Out of State: Meet criteria for Provider eligibility and enter into a provider agreement with the Division of Medical Assistance pursuant to 130 CMR 405.000

Emergency Care. Medical care required immediately due to illness or injury with symptoms of sufficient severity that a prudent lay person would believe there is an immediate threat to life or high risk of permanent damage to the individual's health. Emergency conditions are those which require immediate medical treatment at the most accessible hospital equipped to provide emergency services. Emergency care does not include elective, primary, or urgent care.

Enhanced Global Delivery. The provision and supervision of case management, perinatal counseling (including, but not limited to, obstetrical-risk assessment and monitoring), in addition to pelvic or cesarean delivery, all routine prenatal visits, and on postpartum visit.

Governmental Unit. The Commonwealth of Massachusetts and any department, agency, board, commission, division, or political subdivision of the Commonwealth.

Group Medical Visit. A session conducted by a physician, physician assistant, nurse practitioner, or registered nurse to introduce appropriate health care topics which could include but are not limited to preventive medicine approaches to personal health and safety and to present self-help and personal management information concerning family medicine, adult medicine, sex education, and chronic illness.

Individual Medical Visit. A face-to-face meeting between a recipient and a physician, physician assistant, nurse practitioner, or registered nurse within the community health center setting, for purposes of examination, diagnosis, or treatment.

Individual Mental Health Visit. A face-to-face meeting at the center between a recipient and a psychiatrist for mental health examination and diagnosis. An Individual Mental Health Visit conducted by a person other than a psychiatrist (for example, a psychologist, nurse, physician assistant, social worker, counselor) or provided in a Community Health Center certified as a mental health center is not reimbursable according to the provisions of 114.3 CMR 4.00. Other mental health services provided in a community health centers so certified may be reimbursed according to 114.3 CMR 6.00: Rates of Payment for Mental Health Services Provided in Community Health Centers and Mental Health Centers.

New Program. A community health center which has experienced less than one year of operation as a Provider of community health care services, or has instituted a significant change in service.

Nurse-Midwife Medical Visit. A face-to-face meeting at the center between a recipient and a Nurse-Midwife for prenatal and postpartum services. If a center chooses to be reimbursed by the Enhanced Global Delivery rate set forth in 114.3 CMR 16.00, a nurse-midwife medical visit is not reimbursable.

Physicians. Includes all MDs and Doctors of Osteopathic Medicine (DOs), but does not include psychiatrists.

Primary or Elective Care. Medical care required by individuals or families that is appropriate for the maintenance of health and the prevention of illness. This care includes but is not limited to physical examination, diagnosis and management of illness, ongoing health maintenance, accident prevention and referral when necessary. This care does not require the specialized resources of a hospital emergency department.

Publicly-Aided Individual. A person who receives health care and other services a governmental unit is in whole or in part liable under a statutory program of public assistance.

Supporting Services. These include, but are not limited to, Health Education, Health Outreach, Medical Social Work Services, Nutrition Services (other than the WIC program), and Translation Services.

Urgent Care. Services required promptly to prevent impairment of health due to symptoms that a prudent lay person would believe require medical attention, but are not life-threatening and do not pose a high risk of permanent damage to an individual's health. Urgent care does not include elective, emergency, or primary care.

4.03: Filing and Reporting Requirements

(1) Required Reports: Existing Providers. Unless exempted, each Provider must file the following information according to the schedule cited in 4.03(4).

(a) One (1) electronic and two (2) paper copies of a Division approved community health center cost report and any supplemental schedules as supplied and/or required by the Division.
(b) Two (2) paper copies of financial statements certified by a certified public accountant. In absence of certified statements, the agency may submit uncertified statements or a Balance Sheet and Operating Statement prepared by the health center.
(c) One (1) electronic copy of the Uniform Financial Statement and Independent Auditor's Report completed in accordance with the filing requirements of the Operational Services Division, Department of Administration and Finance, if submission is required by the Operational Services Division.
(d) One (1) paper copy of the Medicare Federally Qualified Health Center Cost Report, as filed with the Medicare fiscal intermediary, if submission is required by HCFA.

(2) Required Reports: Existing Providers - Filing Exemption. A Provider may file a written request to waive the filing requirements set forth in 114.3 CMR 4.03(1) for good cause.

(a) The factors which the Division will consider in determining whether to grant such a waiver, include, but are not limited to, agency size and volume, current MassHealth volume and revenues, current uncompensated care/free care volume, expenditures and revenues, and BlueCross/BlueShield volume and revenues. If an approval is granted, its duration is limited to one fiscal year and, when applicable, the following must be submitted for the waived fiscal year.

(i) Two (2) paper copies of the audited financial statements,
(ii) One (1) electronic copy of the Uniform Financial Statement and Independent Auditor's Report, if applicable, and
(iii) One (1) copy of the Medicare Federally Qualified Health Center Medicare Cost Report, if applicable.

(3) Required Reports: New Providers. New programs shall submit the required documentation cited in 114.3 CMR 4.03(1) and (2) and in accordance with the schedule set forth in 114.3 CMR 4.03(4), upon completion of a full fiscal year of operation.

(4) Filing Deadlines. Each Provider must file the required documents cited in 4.03(1) and (2) according to the following schedule:

(a) For Providers with fiscal periods ending July 1 through December 31, reports are due by December 1 of the following year.
(b) For Providers with fiscal periods ending January 1 through June 30, reports are due by December 1 of the same year.

(5) Additional Information Requested by the Division. Each Provider shall file such additional information as the Division requests within 15 business days from the date of request, unless a different time is specified. The Division may, for cause, extend the filing date of the requested information, in response to a written request for an extension of time.

(6) General Provisions.

(a) Accurate Data. All reports, schedules, additional information, books and records made available to the Division shall be certified under pains and penalties of perjury as true, correct and accurate by the Executive Director or Chief Financial Officer of the community health center.
(b) Examination of Records. Each health center shall make available all records relating to its operation and all records relating to a realty service or holding company or any entity in which there may be a common ownership or interrelated directorate upon request of the Division for examination.
(c) Field Audits. The Division shall determine if a field audit is necessary to substantiate information provided to the Division. The Division shall make reasonable attempts to schedule an audit at a convenient time for both parties.

(7) Non-Compliance. Failure on the part of a Provider to submit accurate and timely information as required in 114.3 CMR 4.03, or to submit other acceptable data and statistics which may be required in the future, may result in the reduction or removal of the rate or rates to which such information is applied.

(a) Penalties. The Division shall impose the following penalties against all rates governed by 114.3 CMR 4.00, that are currently in effect, for failure to comply with the reporting requirements. The penalty will be effective on the day following the date the information is due at the Division. These rates will be reduced for an amount of time equal to the period of non-compliance. The penalty shall accrue at a rate of 5% per month of non-compliance. The penalty shall not exceed a cumulative total of more than 50%. If a Provider is not in full compliance upon completion of the regulation review and the filing of new rates for all centers, at no time can the new rate exceed the penalty-adjusted current rate. If the new rate were to exceed the penalty-adjusted current rate, the filing of the new rate will be delayed until full compliance of the filing requirements. If, on the other hand, the new rate is less than the rate currently in effect, then the new rate will become effective immediately and potentially subject to further penalty.

(8) Mergers, Acquisitions, Other Transfers. Any Providers involved in a merger, buy out, acquisition, purchase, pooling of interest or other arrangement involving the transfer of business will be treated as a single Provider for the purposes of 114.3 CMR 4.03.

4.04: General Rate Provisions and Maximum Allowable Fees

(1) Reimbursement as Full Payment. The rates of payment under 114.3 CMR 4.00 shall constitute full compensation for community health center services provided to publicly-aided as well as full compensation for necessary administration, professional supervision, and supporting services associated with patient care. Any client resources or third party payments received on behalf of a publicly assisted client shall reduce, by that amount, the amount of the purchasing governmental unit's obligation for services rendered to the publicly assisted client.

(2) Rate Determination. Rates of payment for authorized community health center services to which 114.3 CMR 4.00 applies will be the lower of:

(a) The Provider's usual charge to the general public (other than publicly-aided individuals or industrial accident patients) for the same or similar services; or
(b) The schedule of allowable fees set forth in 114.3 CMR 4.05.

4.05: Allowable Fees

Service Code	Allowable Fee	Service Description
(1)		**Medical Diagnosis and Treatment.**
T1015	$97.20	Individual Medical Visit
T1015-HQ	$19.44	Group Medical Visit
99050	$34.03	Urgent Care Provided Monday through Friday from 5:00 P.M. to 6:59 A.M., and Saturday from 7:00 A.M. to 4:00 P.M. (This code may be billed in addition to the individual medical visit.)
99054	$54.61	Urgent Care Provided Saturday 4:01 P.M. to Monday 6:59 A.M. (This code may be billed in addition to the individual medical visit rate.)
T1015-TH	$97.20	Nurse-Midwife Medical Visit
D9450	$ 15.00	Dental Enhancement Fee per Dental User (This code may be billed when dental procedures under 114.3 CMR 14.00 are used. This code can only be billed once per dental user per day.)
(2)		**Early and Periodic Screening, Diagnosis and Treatment Services.**
99381	$102.06	Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures; infant (age under one year)
99382	$102.06	Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures; early childhood (age one through four years)
99383	$102.06	Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures; late childhood (age five through 11 years)
99384	$102.06	Initial evaluation and management of a healthy individual requiring a comprehensive history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures; adolescent (age 12 through 17 years)
99385	$102.06	Initial evaluation and management of a healthy individual requiring a comprehensive

		history, a comprehensive examination, the identification of risk factors, and the ordering of appropriate laboratory/diagnostic procedures; (18 through 39 years)
99391	$102.06	Periodic reevaluation and management of a healthy individual requiring a comprehensive history, comprehensive examination, the identification of risk factors and the ordering of appropriate laboratory/diagnostic procedures, established patient; infant (age under one year)
99392	$102.06	Periodic reevaluation and management of a healthy individual requiring a comprehensive history, comprehensive examination, the identification of risk factors and the ordering of appropriate laboratory/diagnostic procedures, established patient; early childhood (age one through four years)
99393	$102.06	Periodic reevaluation and management of a healthy individual requiring a comprehensive history, comprehensive examination, the identification of risk factors and the ordering of appropriate laboratory/diagnostic procedures, established patient; late childhood (age five through 11 years)
99394	$102.06	Periodic reevaluation and management of a healthy individual requiring a comprehensive history, comprehensive examination, the identification of risk factors and the ordering of appropriate laboratory/diagnostic procedures, established patient; adolescent (age 12 through 17 years)
99395	$102.06	Periodic reevaluation and management of a healthy individual requiring a comprehensive history, comprehensive examination, the identification of risk factors and the ordering of appropriate laboratory/diagnostic procedures, established patient; (18 through 39 years)

(3) Mental Health Examination and Diagnosis.

90899	$97.20	Individual Mental Health Visit

(4) Other Community Health Center Services. The rates of payment for other community health center services, provided to publicly-aided patients shall be based on the applicable regulation and rates of payment for the specific care and services rendered as issued by the Division or the governmental unit where the latter's schedules have not been superseded by 114 CMR. Rules for such care, services, and shall include, but not be limited to, those furnished by dentists, pharmacies, independent clinical laboratories, optometrists, opticians, podiatrists, psychologists, and other individual practitioners and non-institutional providers.

4.06: MassHealth Supplemental Payment

(1) Supplemental Payment Eligibility:
A CHC that meets the requirements of an In-State eligible provider as defined in 4.02 and has received payments prior to May 15, 2004 under the provisions of regulation 114.6 CMR 11.00 shall be eligible for the Supplemental Payment.

(2) Payment Method:
The amount of the prospective payment for each eligible CHC for the Supplemental Payment shall be calculated by multiplying the rate of $30.00 times the annualized number of individual visits (codes T1015, T1015 TH, and 90899) that were reimbursed and documented by MassHealth during the State fiscal year 2004 for dates of service through May 15, 2004. Such Supplemental Payments are subject to Federal approval.

4.07: Adjustment to Ensure Title XIX Access or Quality

A Provider may request an adjustment of rates if it can demonstrate that access to service delivery is threatened. In order to qualify, the Provider must obtain certification from the Division of Medical Assistance that, without an increase in rates, access to services to Medicaid recipients will be jeopardized or that the quality of service will fall below levels acceptable to the DMA and required by Title XIX. If the DMA makes such a certification, the Provider may submit an application for a rate adjustment. The Provider's application must include a copy of the DMA certification, the number of clients in need of the particular service, the number of visits required, evidence of the direct relationship between services and the cost of providing care and the minimal additional costs to adequately provide the services. The Division shall review and act on a request for a change in rates within 60 days of the receipt of a completed application.

4.08: Program Innovation Provision

(1) Review of Program Innovation Applications. A Provider may apply for a prospective adjustment of its Medical Visit Rate or establishment of a rate separate from its Medical Visit Rate in order to implement a high priority policy initiative sponsored by a governmental unit of the Commonwealth. The Division shall review and act on a request for a prospective change in rate or establishment of a rate separate from the Medical Visit Rate within 60 days after receipt of a program innovation application consisting of, but not limited to: a statement of support from the sponsoring state agency which would bear the majority or resultant cost increases; a description of the purpose and scope of the program innovation, including number of personnel involved and proposed implementation process; and a detailed budget of expected additional costs and project volume associated with the program innovation.

(2) Criteria. An agency may apply for a prospective change in rate or establishment of a rate separate from the Medical Visit Rate on the basis of implementing a program innovation which accomplishes current high-priority policy initiatives of a state agency, in which timely implementation is essential.

(3) Implementation Schedule. The Division will not approve an application for an adjustment in rate or establishment of a rate separate from the Medical Visit Rate due to a program innovation unless the Provider demonstrates that it will implement the program within three months of the effective date of the new rate. Dates of implementation and supportive documentation must accompany the application. The effective date of an approved rate will be the date on which the most costs are incurred by the agency for the implementation of the program. Evidence of expenditures must be submitted to the Division within three months of the effective date of the approved rate. The Division reserves the right to lower the rate retroactive to the date on which the program innovation became effective if the program innovation is not implemented or if actual costs are lower than projected.

4.09: Administrative Information Bulletins

(1) Information Bulletins. The Division may, from time to time, issue administrative information bulletins to clarify its policy on substantive provisions of 114.3 CMR 4.00. In addition, the Division may issue administrative information bulletins which specify the information and documentation necessary to implement 114.3 CMR 4.00.

(2) Coding Updates and Corrections. The Division may publish procedure code updates and corrections in the form of an Informational Bulletin. Updates may reference coding systems including but not limited to the American Medical Association's *Current Procedural Terminology* (CPT). The publication of such updates and corrections will list:

(a)codes for which only the code numbers change, with the corresponding cross references between existing and new codes;
(b)deleted codes for which there are no corresponding new codes; and
(c)codes for entirely new services that require pricing. The Division will list these codes and apply individual consideration (I.C.) reimbursement for these codes until appropriate rates can be developed.

4.10: Severability of the Provisions of 114.3 CMR 4.00

The provisions of 114.3 CMR 4.00 are severable, and if any provision of 114.3 CMR 4.00 or application of such provision to any community health center or any circumstances shall be held to be invalid or unconstitutional, such invalidity shall not be construed to affect the validity or constitutionality of any remaining provisions of 114.3 CMR 4.00 or applications of such provisions to community health centers or circumstances other than those held invalid.

REGULATORY AUTHORITY

114.3 CMR 4.00: M.G.L. c. 118G